

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11496

CERTIFICATE OF DEATH

11500

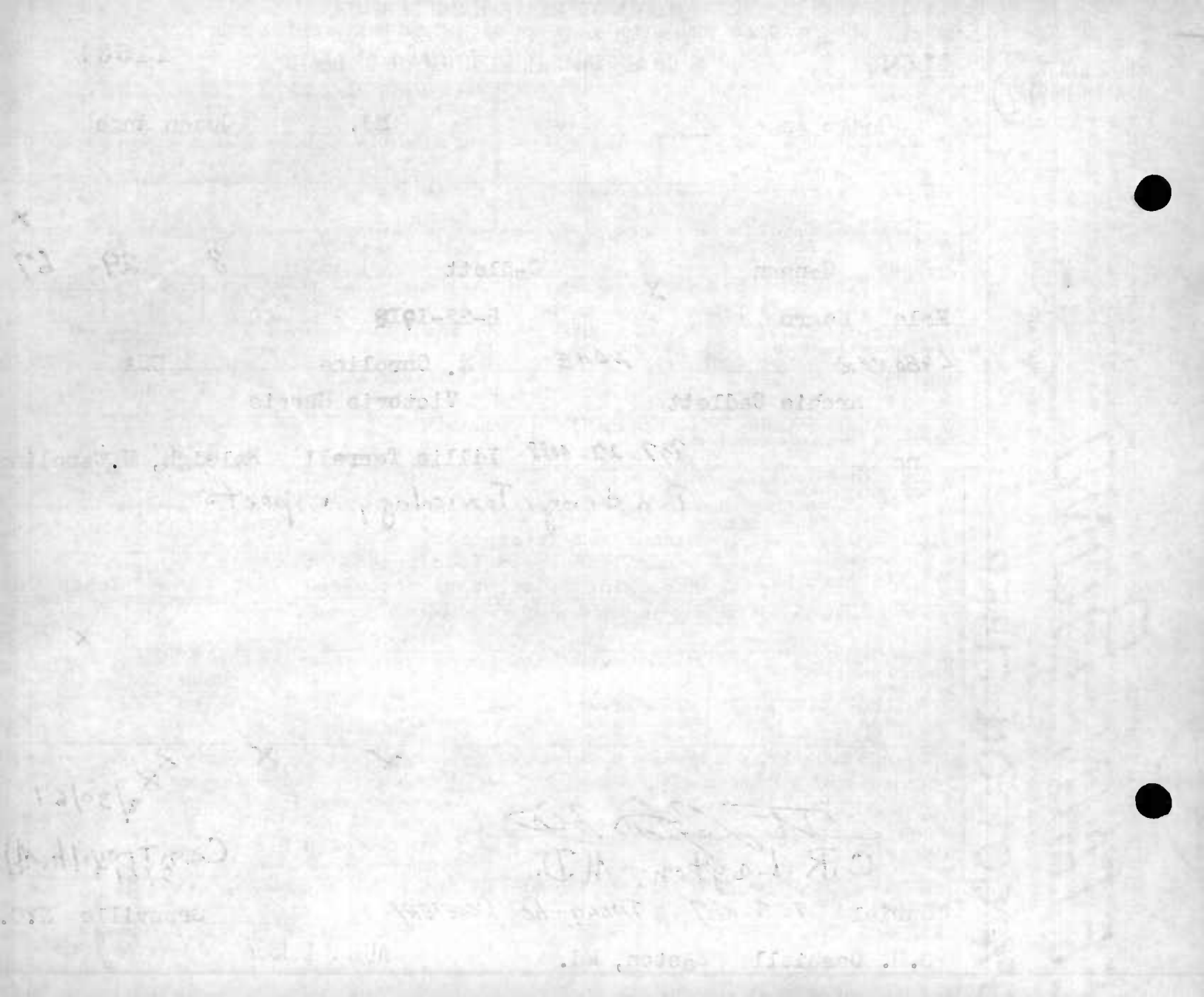
1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE'S</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE'S</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>QUEENSTOWN</u>		c. LENGTH OF STAY IN 1b <u>35 YRS.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>QUEENSTOWN</u> 17-1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANCES Woolford Beecher</u>		4. DATE OF DEATH Month Day Year <u>August 18, 1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 13, 1912</u> 55 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WIFE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ridgely, CAROLINE Co, Maryland U. S. A.</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>HENRY Clay Woolford</u>		14. MOTHER'S MAIDEN NAME <u>ANNA GREAVES</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>HUSBAND</u> Address <u>VIRBROOK BEECHER QUEENSTOWN, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 21. I certify that (I) <u>this hospital</u> attended the deceased from <u>7-20</u> , 19 <u>67</u> , to <u>8-18</u> , 19 <u>67</u> , that (I) <u>saw</u> the deceased alive on <u>8-13</u> , 19 <u>67</u> , and that death occurred at <u>5:55 AM</u> , from causes and on the date stated above.			INTERVAL BETWEEN ONSET AND DEATH <u>10 MIN.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CONGESTIVE HEART FAILURE</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) <u>this hospital</u> attended the deceased from <u>7-20</u> , 19 <u>67</u> , to <u>8-18</u> , 19 <u>67</u> , that (I) <u>saw</u> the deceased alive on <u>8-13</u> , 19 <u>67</u> , and that death occurred at <u>5:55 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Ralph E. Libby</u>		22b. DATE SIGNED <u>8-20-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ralph E. Libby, M.D.</u>		22d. ADDRESS <u>Grasonville, Maryland 21638</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>August 21, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chesterfield Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Chesterfield, PA Co Md.</u>
24. FUNERAL DIRECTOR <u>James H. Barton Jr. - Barton Bros. Centerville, Md.</u>		25a. REC'D BY REGISTRAR <u>James H. Barton Jr.</u> 25b. REGISTRAR'S SIGNATURE <u>James H. Barton Jr.</u>	

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 1 & 21 Film 392		MARYLAND STATE DEPARTMENT OF HEALTH	
9-15-67 ams		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	
Item #1b & d & 2c & d Film #G392 9/6/67 ph		MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
11497		11501	
1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Centreville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>private residence</u>		d. STREET ADDRESS <u>RFD</u>	
3. NAME OF DECEASED (Type or print) <u>Cannon</u> First Middle Last		4. DATE OF DEATH Month <u>8</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>5-22-1918</u>		9. AGE (In years last birthday) <u>49</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>N. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Archie Cadlett</u>		14. MOTHER'S MAIDEN NAME <u>Victoria Harris</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>237-22-0088</u>	
17. INFORMANT <u>Lillie Terrell</u>		Address <u>Raleigh, N. Carolina</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>4201</u> IMMEDIATE CAUSE (a) <u>Poisoning / Toxicology / reports /</u> DUE TO (b) <u>Myocardial infarction</u> DUE TO (c) <u>Generalized arteriosclerosis with narrowing of coronary arteries</u>		INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>		22. DATE SIGNED <u>8/30/67</u>	
ACTUAL SIGNATURE <u>C.R. Layton</u> M.D. EXAMINER'S NAME (Type) <u>C.R. Layton, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) <u>Centreville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-3-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>TALLY-HO CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>Granville N.C.</u>	
24. FUNERAL DIRECTOR <u>G.H. Dashiell</u>		25. REC'D BY REGISTRAR DATE <u>AUG 31 1967</u>	
ADDRESS <u>Easton, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
11498					11503					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY Queen Anne's MARYLAND					a. STATE Maryland b. COUNTY Kent					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Church Hill					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Betterton					
c. LENGTH OF STAY IN 1b 2 years					d. STREET ADDRESS -----					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Colonial Arms Nursing Home					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH		Month Day Year		
Evelyn B. Harris					August 23, 1967					
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Dec. 6, 1884		82 yrs.	Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charles Bockmiller					14. MOTHER'S MAIDEN NAME Jessie H. Baynard					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 213-12-5187-T		17. INFORMANT Address Arthur L. Harris Worton, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio Vascular DUE TO disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchio Pneumonia DUE TO 1 week (c) 1 year									INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C. V. A. 1965									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Aug 17, 1967 to Aug 23, 1967 , that (I) (we) last saw the deceased alive on Aug 23, 1967 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.										
22a. SIGNATURE C. Rodney Layton					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED P-24-67	
22c. PHYSICIAN'S NAME (Type) C. Rodney Layton M.D.					22d. ADDRESS 104 S. Liberty Av., Centreville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-26-67		23c. NAME OF CEMETERY OR CREMATORY Still Pond Cemty.		23d. LOCATION (City, town or county) (State) Still Pond, Kent, Md.				
24. FUNERAL DIRECTOR Victor N. Kennedy					ADDRESS Still Pond, Md.		25a. REC'D BY REGISTRAR AUG 25 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

2293

11499

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11504

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Queen Anne's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Q.A.Co;	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington. Rural		c. LENGTH OF STAY IN 1b 17-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First DOROTHY Middle SOPHIA Last JOHNSON		4. DATE OF DEATH Month August, Day 14, Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 14, 1928
9. AGE (In years lost birthday) yrs. 38		10. IF UNDER 1 Year Months 14 Days 19 Hours 67 Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		12. KIND OF BUSINESS OR INDUSTRY Home	
13. BIRTHPLACE (State or foreign country) North Carolina		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. FATHER'S NAME Dan Edwards.		16. MOTHER'S MAIDEN NAME Bessie Cain	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		18. SOCIAL SECURITY NO.	
19. INFORMANT Robert Edwards,		Address Millington, Md. 21651	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 880.9 IMMEDIATE CAUSE (a) Acute Alcoholism DUE TO (b) Alcohol poisoning Bl alcohol .43 DUE TO (c) Unknown		INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Known Epilepsy		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		22. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Brought home by friends	
23. 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		24. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
25. 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		26. 20f. (City or town) (County) (State)	
27. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
28. ACTUAL SIGNATURE C. Rodney Layton		29. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
30. EXAMINER'S NAME (Type) C. Rodney Layton, Centreville, Md.		31. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
32. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		33. ADDRESS (Street, city, town, or county) Centreville, Md.	
34. 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	35. 23b. DATE THEREOF Aug. 18, 1967	36. 23c. NAME OF CEMETERY OR CREMATORY Sudlersville Cemetery.	37. 23d. LOCATION (City or Town) (County) (State) Sudlersville, Q.A.Co; Md.
38. 24. FUNERAL DIRECTOR Edward Elbow		39. ADDRESS Millington Md. 21651	
40. 25a. REC'D BY REGISTRAR DATE AUG 21 1967		41. 25b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE
HEALTH DEPT.

11500

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11505

1. PLACE OF DEATH a. COUNTY Queen Anne MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD Chestertown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD Chestertown 17.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) At Home - in Kingstown		d. STREET ADDRESS Kingstown	
3. NAME OF DECEASED (Type or print) Madeline Rollison Porter		4. DATE OF DEATH Aug. 30, 1967	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years lost birthday) 54 yrs.
9. IF UNDER 1 YEAR Months Days		10. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin Rollison		14. MOTHER'S MAIDEN NAME Emily Williams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214 18 4537	
17. INFORMANT Charles Porter		Address RFD Chestertown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 9731 IMMEDIATE CAUSE (a) Carbon Monoxide Poisoning DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 30 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Started 3 engine motors in garage & closed doors	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 3:45 p.m. 9/30/67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Chestertown (County) 2A (State) MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE C. Rodney Layton M.D.		22. DATE SIGNED 8/30/67	
EXAMINER'S NAME (Type) Queen Anne County - Maryland		Address (Street, city, town, or county) Centerville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/1/67	
23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		23d. LOCATION (City or Town) (County) (State) Chestertown, Md.	
24. FUNERAL DIRECTOR Willis Wells		ADDRESS Chestertown, Md.	
25a. REC'D BY REGISTRAR SEP 5 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

11501

Item #7 Film #G391 8/14/67 ph

CERTIFICATE OF DEATH

11506

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>	
c. LENGTH OF STAY IN 1b <u>10 Yrs.</u>		d. STREET ADDRESS <u>17-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Eddie</u> Middle <u>Lee</u> Last <u>Rankins</u>		4. DATE OF DEATH Month <u>August</u> Day <u>2</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/12/27</u>
9. AGE (In years last birthday) <u>39</u> yrs.		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>16</u> Hours <u>17</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Oystering</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Chowae, N. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jordan Rankins</u>		14. MOTHER'S MAIDEN NAME <u>Anna Belle Taylor</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>244-10-1094</u>	
17. INFORMANT <u>Mrs. Christine Askins</u>		Address <u>Chester, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>493X</u> IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ALCOHOLISM</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7-30</u> , 19 <u>67</u> , to <u>8-2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-30</u> , 19 <u>67</u> , and that death occurred at <u>5:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Ralph E. Libby</u>		22b. DATE SIGNED <u>8-7-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ralph E. Libby, M.D.</u>		22d. ADDRESS <u>GRASONVILLE, MD. 21638</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>8-6-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chester</u>	23d. LOCATION (City or Town) (County) (State) <u>Chester Queen Anne Md</u>
24. FUNERAL DIRECTOR <u>G.H. Dashiell</u>		ADDRESS <u>Easton, Md.</u>	
25a. REC'D BY REGISTRAR <u>AUG 11 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1990

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11502

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11507

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE'S</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE'S</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CENTREVILLE</u>		c. LENGTH OF STAY IN IT <u>most of life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>OSCAR</u> Last <u>SPARKS</u>		4. DATE OF DEATH Month <u>August</u> Day <u>14</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 8, 1893</u>
9. AGE (In years last birthday) yrs. <u>73</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM OWNER</u>	
11. BIRTHPLACE (State or foreign country) <u>CENTREVILLE, D.A. Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WALTER SIMPLER SPARKS</u>		14. MOTHER'S MAIDEN NAME <u>MINNIE McClyment</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-36-0756</u>	
17. INFORMANT <u>Son</u>		Address <u>Willard M. Sparks, Centreville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Coronary Occlusion</u> DUE TO (b) <u>Hypertensive Cardiovascular</u> DUE TO (c) <u>disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>C. R. Layton</u>		22. DATE SIGNED <u>P-15-67</u>	
EXAMINER'S NAME (Type) <u>C. R. Layton</u>		Address (Street, city, town, or county) <u>Centreville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>August 16, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Chesterfield Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>CENTREVILLE, D.A. Co., Md.</u>	
24. FUNERAL DIRECTOR <u>John H. Baitz</u>		25a. REC'D BY REGISTRAR <u>AUG 17 1967</u>	
Address <u>Centreville, Md.</u>		25b. JUSTICE SIGNATURE <u>John H. Baitz</u>	

1912

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